Notes From My Diary

Facilitation Guide

Training Module for STI/RTI Counsellors

suraksha clinic

NACO
National AIDS Control Organisation
India's voice against AIDS

Introduction

The National AIDS Control Programme in its third phase is undertaking an extensive capacity-building exercise for Counsellors posted at STI/RTI clinics in government hospitals. The 11 day training package developed includes a variety of components and visual aids to support the trainer in facilitating the sessions that cover a vast range of subjects and themes.

The film 'Notes from my diary' was developed to equip the STI/RTI counsellors with a better understanding of the skills, attitudes and protocols to be observed while dealing with a variety of clients. Through the experiences of a fictional character, a counsellor named Swati, the film commences with a generic overview of the essential stages and requirements of good counselling, and then proceeds to capture four counselling 'cases' that feature clients with 'higher risk behaviour' in the context of STI/RTI and HIV/AIDS.

The use of films for training, specifically through the depiction of case studies, engages the audience through a more dramatic and attention-grabbing method than printed case-materials. Sometimes scenes from films can offer a symbolic way of communicating theories and concepts. The visual and auditory effects of films can often convey a message better than printed or spoken words.

Given that a film such as this necessarily operates within the constraints of a fixed time frame, the emphasis in each case has been to focus on a few key priority issues. Thus the film does not cover each counselling session in its entirety and we catch the session from a point which highlights the priority issue.

'Notes from my diary' has been developed as a film that may be used by trainers to stimulate discussion and reflection on key aspects including the content as well as processes and skills in counselling. In order to enhance the ability of the trainer to use the film optimally, this facilitation guide has been developed as a tool to be used in conjunction with the film. The film may be used in part or whole, depending upon the requirements and needs of the group the facilitator is working with.

Tips for using the film and guide

The facilitator should read the entire guide before the session. Some issues covered in the case-studies may be

common across different cases; others may be specific to a case study. The cases may be used one at a time, followed by a pause and discussion around the case. Based on availability of time and group size, the debrief/discussion session may be activity-based, as in small group discussions.

- Before showing the film it would be important to clearly state the objectives and expected outcomes of the screening, as also the process that would be followed in using this training tool

- After screening the film, (either in it's entirety or in a 'capsule' format, pausing after each case), the facilitator would stimulate discussion around key issues depicted, using this facilitation guide as a 'ready-reckoner' to refer to. It would be useful to ensure focused discussion so that the film leads to effective translation of learning outcomes. Cross-references to learning acquired through the other sessions of the training module may also be made

- It may be useful to repeat scenes if required. Repeating scenes is especially helpful when trying to develop participants' understanding of complex topics. If required, the film may be paused within a case study, if the trainer feels the need to generate discussion around a particular frame

- While the facilitation guide focuses on each specific case, it would be useful to also explore comparisons across cases, in terms of style and approach of the counsellor, issues raised, and such like


A World
Free of

Introduction to Counselling

The film is introduced through a narrator (counsellor) who shares her learnings and experiences in counselling. She walks the audience through the stages of counselling as well as some of the essential skills required. The facilitator may use this introduction section of the film to generate a discussion on three major areas:

1. The TOR (Terms of Reference) for a counsellor at an STI/RTI clinic
2. Standard Operating Procedure to ensure quality counselling services
3. Basic counselling skills required for counselling clients at STI/RTI clinics

Screen the introduction section of the film and pause before the first case study. Depending upon the time availability, you may commence the discussion by facilitating a brainstorming session around each of the above three topics. Take one issue at a time, and note down the participants' responses on a white board or flip chart. Summarize using the debrief points presented below for each section. Add on to the debrief points by providing examples. Link the session content to other modules covered through the training.

1. What is the TOR for a counsellor at the STI/RTI clinic?

As per the Terms of Reference and Scope of Work of a counsellor at the STI/RTI clinic, she/he is expected to

Offer counselling inputs:

- Inform and counsel the client on the infection
- Motivate clients to undergo treatment for STI/RTI, HIV testing, and to follow safe practices
- Motivate clients to undergo periodic syphilis testing
- Encourage partner or spouse treatment and testing
- Discuss reproductive health and related issues

Maintain records:

- Document counselling sessions and maintain client records in prescribed formats
- Provide monthly reports on the clinic's activities

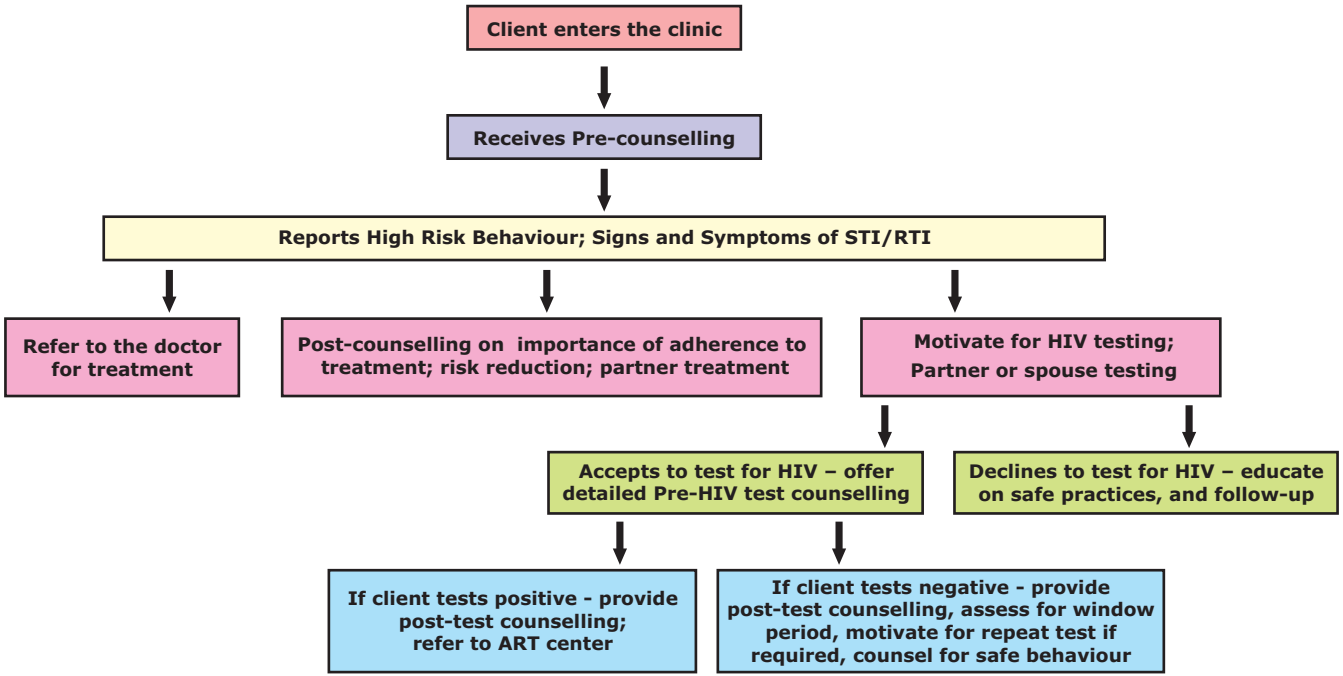
Develop referrals and linkages:

- Assess needs and make referrals for additional services
- Establish linkages with other service providers, medical, legal and social services

2. What should be the Standard Operating Procedure to ensure quality counselling services?

The facilitator can draw the flow chart on the board/ request a volunteer to come up and draw the same. The importance of each stage is then discussed with the group.

FLOW CHART FOR STI/RTI COUNSELLING



3. What are the basic counselling skills a counsellor would require at the STI/RTI clinic?

Generate a discussion among the participants on the skills required, and note these down on a flip-chart as they are mentioned. Encourage participants to come up with examples of situations that would require the skills mentioned. Ensure that the following are covered during the discussion.

- Ability to develop rapport: The counsellor should establish
  - A relationship with the client to allow free and open interaction
  - A partnership where the counsellor and client are both active participants

- Verbal and non-verbal communication: The counsellor should
  - Use appropriate body language such as eye contact, sitting in a relaxed position, nodding, using suitable verbal responses such as 'hmmm, I see...'
  - Listen to the client's language and adapt one's language to meet theirs, without mimicking them. It's useful to listen for key words, which indicate important issues for the client, and to pay attention to what the client is saying.
  - Not write and listen at the same time. It's important to give your full attention to listening and then make notes with the client's permission if necessary.

- Counsellor should check that they have understood the client by repeating what the client has said (paraphrasing) or summarizing.

- Simple and straightforward questions help clients to talk freely and explore their situation in depth. Using open-ended questions such as 'can you tell me more about yourself?' that encourage clients to talk more freely are better than 'closed' questions, which have a 'yes' or 'no' answer.

- The counsellor should
  - Be knowledgeable about the issues concerning the client.
  - Provide full, correct, accurate, honest and clear information as is needed in ways that are relevant to the client. The counsellor should not give false reassurances for example, 'I assure you...'
  - Assist the client by providing new ways of looking at

a situation. For example, information may be provided about other service providers or a range of safer sex activities.

- Help clients to identify others that they can rely on and receive help from. This might include the family, friends, support groups, primary health care providers, social welfare, police and the courts, and local non-profit NGO and CBOs.

- Counselling is not a one-time activity; counsellors must provide ongoing support as needed and wanted by the client.

CASE-STUDY 1: RANI'S CASE

Rani is a Female Sex Worker. She comes to the clinic with symptoms of STI/RTI. However, she lacks knowledge and proper understanding on the same. She reports using condoms, however admits that she may miss out on the same occasionally. She has a regular partner, with whom she does not use a condom.

Ask any participant to volunteer to summarize the case study presented in the film clip, highlighting important issues covered in the film. Generate a discussion by asking the participants the following questions:

1. In the case just screened, Rani, the client, lacks **knowledge and information on STI/RTI.** What approach can be used to introduce the discussion on this?

2. **Communication skills:**
   a. Discuss Swati's style of communicating with Rani. What were the strong points in the communication? What could be areas for improvement?
   b. What are the dos and don'ts of verbal and non-verbal communication?
   c. Rani is not very educated; how can counsellors explain technical information on STI and HIV in such situations?

3. **Counselling skills:**
   a. Discuss the use of specific counselling skills in the case.
   b. What other skills may be used to enhance the effectiveness of the counselling?

4. **Risk perception, assessment and reduction:**
   a. In case Rani on being asked, 'Do you have time to discuss information in detail?' had replied 'no', how could Swati have dealt with the situation?
   b. What are some risk reduction options a counsellor could discuss with a Female Sex Worker?

5. **Follow up:**
   a. In case the doctor detects Rani with Vaginal Discharge, then what would Swati's role be in counselling her?

b. Why should Rani return next week after medicines are given to her?

6. What do you think about the **environment** in which Swati was conducting her counselling sessions?

Points to cover in the discussion:

1. **In the case just screened, Rani, the client, lacks knowledge and information on STI/RTI. What approach can be used to introduce the discussion on this?**

   Most counsellors would assume that clients who have come to the STI clinic, would know why they are there. The assumption that a client knows why she/he has been referred to a counsellor is often a mistaken one. It is also possible that for the client there may be several other issues that are of immediate concern, and STI may not be one of them. In such as situation, it is advisable for the counsellor to encourage the client to tell her/his own story by facilitating the process through open-ended questioning. Examples of such questions include 'What brings you here today?', 'Where would you like to begin?', 'Is there anything else on your mind?', 'What else has been happening?' and such like. Once the rapport has been established, the counsellor may then move on to the next stage and deal with the specific issues that are raised.

2. **COMMUNICATION SKILLS**

   a. **Discuss Swati's style of communicating with Rani. What were the strong points in the communication? What could be areas for improvement?**

   Communication is the process of sending and receiving messages, either verbally or non-verbally, between the counsellor and the client. Communication skills with a client would include:

   - **Empathy:** It involves trying to place oneself in another's situation. Empathy is very often conveyed not in words, but through non-verbal communication like nodding the head etc. It may express a statement of support. Empathy is different from sympathy.
   - **Active listening:** It involves indicating by words, expression and postures/gestures that attention is being given to what is being said. It facilitates free expression of whatever is in the

client's mind and helps the client open up.

- **Being non-judgmental:** It involves viewing the clients as individuals with problems and respecting them without judging or condemning their past behaviour.
- **Giving and receiving feedback:** It involves giving positive comments/feedback and then talking to clients on their weakness or mistakes. It includes beginning sentences with 'I' as these are only subjective feelings and views and using simple words and short sentences.
- **Verbal and non-verbal communication:** It includes verbal ('I see' or 'Go on') and non-verbal (nodding occasionally or gesturing) responses that a counsellor provides to support the counseling process. These can be supportive or non-supportive within a particular cultural context.

There is no ideal way to communicate with a client. The counsellor should be able to adapt to the client, and provide information by using simple terminology in the local language. The counsellor may use metaphors to explain issues. Swati displays a non-judgmental attitude in her interactions with Rani. By reassuring her of confidentiality, she is also able to get Rani to become comfortable enough to open up to her. However, she could have used more of open-ended, as against close-ended, questions to explore Rani's feelings and attitudes better.

b. What are the dos and don'ts of verbal and non-verbal communication?

Some important non-verbal cues the counsellor could use in a session like the present case include:

- **Body Posture:** If used effectively, body posture can communicate confidence, as also an interest in listening to what the client has to say. Negative posture can communicate hierarchy and hinder rapport development.
- **Eye contact:** Maintaining eye contact with client when the counsellor speaks and when the client speaks is very important. Looking down at record books or around the room could make the client feel uncomfortable. It may also indicate pre-occupation with other activities and the client may feel neglected.

- **Gestures with hands and arms:** Some counsellors may be in the habit of gesticulating a lot when they speak. It would be useful to observe the client's response to such movements. Some clients may get distracted on account of this.
- **Speech:** The counsellor should always be simple and clear in speech to ensure the client can follow what is being said. The tone of voice should be moderate to low, indicating a friendly interaction.

The facilitator should emphasize that effective communication will encourage the client to openly discuss sensitive issues with a counsellor. The client will be able to gain a wider range of information relating to the infection, giving them access to many solutions to their problems. This in turn can help clients make informed choices.

Often, a heavy workload may lead a counsellor to provide information rather than listen to the client. Active listening is an essential element of an effective communication process. The counsellor should not interrupt and divert the client or take on the role of inquisitor and ask too many questions out of curiosity.

c. Rani is not very educated; how can counsellors explain technical information on STI and HIV in such situations?

In any situation, whether with 'educated' or 'less educated' clients, it is important to simplify technical terms and avoid the use of jargon. Using simple analogies and examples can help in the process. Above all, client education tools, demonstration models, and IEC support materials, are valuable aids in communicating on complex technical issues. These help to ensure that clients understand and retain information accurately. Besides aiding the counsellor, they bring in an element of interest in the client-counsellor interaction and help focus attention.

Visual images not only help clients understand but also aid in better and more correct recall of information. The counsellor should keep visual aids

in a place that is easily accessible, for example, in front of them on the table. Clients can also be provided handouts as take home materials.

3. COUNSELLING SKILLS

a. Discuss the use of specific counselling skills in the case.

While generating the discussion, do cover the following skills, and encourage participants to analyze how Swati displayed these skills, and areas where she could have applied them better.

- **Reflecting skills:** Telling the other person what you think they are feeling. For example, 'You're anxious about your health...'
- **Paraphrasing skills:** Putting in different words what the client said and checking that you have heard it correctly. For example, 'So you're saying that your partner may not be at risk...'
- **Being non-judgmental:** Judging involves imposing your values on the client and giving solutions to their problems. For example, a counsellor's personal value system may lead her to look down upon sex work; such a belief may get unwittingly transferred to the client during the session

REMEMBER TO AVOID!

- Criticizing the client - 'You don't understand...?'
- Calling names - 'You are stupid...'
- Diagnosing - 'You are not really capable of...'
- Praising to manipulate a person - 'I am sure you can do a lot better if you tried'
- Sending solutions - Do not interrupt before the client has finished by giving your idea of a solution before being asked
- Moralizing - 'Being a FSW is bad, you need to give up your profession'
- Threatening - 'If you don't listen to me...'
- Excessive/inappropriate questioning - 'Where did you go? What did you do? Who were you with?'
- Finishing sentences for the client
- Advising - 'It would be best if you...'
- Excessive reassuring - 'It will all work out'; this may make the person feel better but may not help in dealing with the problem
- Discounting - 'Yes, but...'

As a counsellor, it is important to remember that all clients deserve respect, whatever their age, marital status, occupation or gender.

b. What other skills may be used to enhance the effectiveness of the counselling in Rani's case?

Generate a discussion around Rani's query- 'but will I be cured?' Discuss what could have led Rani to ask this, and if Swati could have addressed these anxieties better, and if so, how. It could be possible that Rani was pre-occupied with other concerns and hence was not paying adequate attention to what Swati was saying. For example, some of her concerns could be 'Will she get clients if she has STI? What will happen to her income? What will she tell her regular partner?' etc. It is important that as a counsellor, one stops in between the provision of information to check that the client has understood and is engaged in what one is saying.

4. RISK PERCEPTION, ASSESSMENT & REDUCTION

a. In case Rani on being asked, 'Do you have time to discuss information in detail' had replied 'no', how could Swati have dealt with the situation?

A situation such as this can arise on account of many reasons. For example, the FSW may come to the clinic when it is her working hours and hence may be in a hurry to leave; she may be very anxious and is eager to get quick treatment for her symptoms, may lack awareness and knowledge on STI, or may not perceive that her health is at risk in any significant manner. It is important for the counsellor to identify the reason behind the refusal. The counsellor may then provide an appointment at a convenient time, provide basic information to create awareness, give her take home handout for reading etc.

Establishing rapport with the client is very important. If the counsellor has developed adequate rapport, the client would feel comfortable is spending time with the counsellor.

Also, choosing the right words to phrase questions in a open-ended manner is essential. The counsellor may tell the client, 'There are some important issues relating to your health that we need to

discuss, it would be good if you can spend some time with me and listen to the same. Would you have time now or would you like to come back? This information is very important for your health.'

b. What are some risk reduction options a counsellor could discuss with a Female Sex Worker?
Discuss the risk reduction options that Swati presents to Rani. Encourage brainstorming on other options that could have been discussed. While generating the discussion, some of the points given below may be noted.

Female Sex Workers like Rani are at risk for both STI and HIV. As Rani has both a regular partner as well as other clients, it is important to encourage screening for STI and HIV testing.

Many Female Sex Workers may have financial compulsions that govern condom use. The conditions under which they operate for example, in the bushes near the highway where there are no lights, also reduces the possibility of condom use. Empowering FSWs to ensure safe sex practices is thus important. Any sexual practice that does not let someone else's semen, blood, or vaginal fluids get into someone else's body is generally considered 'safer' sex. Safer sex often involves use of latex condoms, latex dental dams, etc which serve as barriers between the infectious fluids and mucous membranes or open cuts.

There are a wide variety of condoms in the market. These can be lubricated or non-lubricated. They come in different colors, shapes, sizes, textures and thickness. There are condoms that are flavoured and those that glow in the dark. Counsellors can encourage clients of FSWs to try out different brands and types of condoms and select the ones with which they are more comfortable. In addition, it is important to demonstrate condom use to each client as well as provide information on where these are available. FSW could learn different techniques that could make promoting condom use among their clients pleasurable. Building negotiation skills is an important component of risk reduction counselling.

The importance of bringing one's regular partner for screening cannot be underestimated; ***discuss suggestions that Swati can offer to Rani to***

persuade her partner to come for treatment.

5. FOLLOW UP

a. In case the doctor detects Rani with Vaginal Discharge, then what would Swati's role be in counselling her?

Swati should explain in clear and simple language what Vaginal Discharge is. She should encourage Rani to take the treatment and follow safe sex practices. She should also encourage her to come for regular medical examination, blood test and treatment as required.

` **b. Why should Rani return next week after medicines are given to her?**

Follow-up is important as the doctor can check on treatment compliance and further treatment if required. It is also important to empower FSWs on safe sex practices, and this is an area that requires more than one meeting/interaction to do well.

6. What do you think about the environment in which Swati was conducting her counselling sessions?

The space provided for counselling appeared adequate and offered privacy. However, the counsellor may arrange the furniture as per her convenience. It is important to have posters and information on the wall to assist the counsellor and convey important messages. Placing flipcharts, penis models and condoms at a handy place for easy access is important.

CASE-STUDY 2: MAYANK'S CASE

Mayank is a 35 year old Injecting Drug User. He recently lost his employment on account of his drug dependence. He appears depressed and reports feeling weak. He admits sharing needles occasionally and having unprotected sex when intoxicated.

Ask any participant to summarize the case study presented in the film clip highlighting important issues covered in the film. Generate a discussion by asking the participants the following questions:

1. Why are **IDUs vulnerable to HIV?**
2. Describe **HIV prevention strategies among IDUs.**
3. **Communication skills:**
   a. In the present case the counsellor addresses the client by name. The facilitator could seek the opinion of participants by asking them the merits and demerits of doing this, and the cultural sensitivities involved, if any.
   b. The counsellor in the case study uses a mix of Hindi and English words. Discuss how counsellors can deal with language issues.
   C. Mayank's response on being asked about whether he sometimes has sex under the influence of drugs was somewhat aggressive and defensive. Discuss how Swati dealt with the situation. What other strategies may be used to deal with aggressive clients?
4. What kind of **IEC/demonstration material** could the counsellor have used in this situation?
5. Can the gender of the counsellor influence the counselling situation? How can a counsellor work around **gender issues**?
6. Swati refers Mayank to a **Drop-in-Centre (DIC)**. What are the services an IDU can access in a DIC? Discuss how referrals can be done in an effective manner.

Points to cover in the discussion:

1. Why are IDUs vulnerable to HIV?

There are a number of factors that make IDUs vulnerable to HIV. Drug users face a huge risk on account of sharing of contaminated needles and other

drug paraphernalia. Under the influence of drugs, they may also find themselves engaging in unprotected sex, which increases their chances of HIV infection. Beyond the obvious physical risks associated with drug injection, drug users may also be vulnerable to HIV because of their social and legal status. They often live on the fringes of society, away from family and friends and beyond the reach of health, education or treatment programmes; many drug users simply do not see themselves as vulnerable to HIV infection and do not test for the virus.

2. Describe HIV prevention strategies among IDUs

The most common strategy followed in IDU Targeted Intervention programmes is harm reduction. Harm reduction aims at reducing or minimizing the actual or potential harm from drugs, but not drug use per se. Examples of harm reduction interventions include Needle Exchange and Oral Substitution Therapy.

The most important goal of counselling with IDUs is to encourage them to stop using drugs. If this is not achievable immediately, then they should be encouraged to smoke or inhale their drugs and stop use the injecting mode. If this is also seen to be very difficult, then they are encouraged to use their own needle and syringe but not share injecting equipment with others.

A significant proportion of drug-dependent individuals may be unwilling or unable to stop injection drug use and do not have access to new or sterile needles and syringes. Encouraging harm reduction strategies such as use of bleach disinfection of injection equipment is an important strategy to reduce the risk of HIV infection from reusing or sharing needles and syringes when no safer options are available.

It is also important to counsel IDU clients for safer sex options. In the film Swati suggests that Mayank should keep a condom with him at all times. In an intoxicated state a client could be at potential risk on account of unprotected sexual behaviour. Repeated instructions and reminders on the importance of consistent condom use become important.

3. COMMUNICATION SKILLS:

a.In the present case the counsellor addresses the client by name. The facilitator could seek

the opinion of participants by asking them the merits and demerits of doing this, and the cultural sensitivities involved, if any.

There are no rules as to how a counsellor addresses a client. The basic principles of regard and respect are to be followed at all times. The counsellor should be sensitive to local culture when addressing clients; addressing a client by name could show familiarity and recognition of her/him as an individual, which some clients would appreciate and view as an indication of trust and rapport.

b. The counsellor in the current case-study uses a mix of Hindi and English words. Discuss how counsellors can deal with language issues.

The key principle is to use language in a manner that is simple and comprehensible to the client. In the Indian context, several English language words have come to be absorbed in the day-to-day speech of non-English-speaking populations (for example, words like infection, stress, tension, treatment etc). However, it is important to avoid using technical terms, and care should be taken to ensure that the client follows what the counsellor is saying. Also, the counsellor should be well versed with relevant local terminology, slang, and ideally, the local language of the place of work, although there may nevertheless be situations, such as with migrant populations for example, where language may prove to be a challenge in effective communication.

c. Mayank's response on being asked about whether he sometimes has sex under the influence of drugs was somewhat aggressive and defensive. Discuss how Swati dealt with the situation. What other strategies may be used to deal with aggressive clients?

Swati did not insist on discussing the issue, but waited for Mayank to calm down and then asked him whether he would like to continue the discussion on the matter. This was an effective strategy that avoided confrontation and power struggle of any kind, and led to Mayank assuming a level of personal responsibility for change.

As a counsellor it is important to observe the client's body language closely. Mayank was very fidgety from the commencement of the session. This could have indicated a high level of anxiety in him. In such situations it helps if the counsellor addresses the

client by asking open-ended questions and reflecting the client's thoughts for example, 'you seem anxious...'

4. What kind of IEC/demonstration material could the counsellor have used in this situation?

A variety of tools are available such as charts, pictures, posters, models and others that aid in information provision. Demonstration items that explain how a needle is cleaned, for example, would be useful in such a situation. Flip books that help focus attention on specific technical aspects are also useful. Such items should be kept within ready reach.

5. Can the gender of the counsellor influence the counselling situation? How can a counsellor work around gender issues?

The key issue in counselling is not the gender of the client and counsellor, but 'gender attitudes'. The comfort level of a counsellor in counselling clients of the opposite sex assumes more importance and it is found that a good counsellor can focus the interaction on the issues being discussed, without letting her/his own gender influence the counselling process and outcomes. It is important that the counsellor should have adequate subject knowledge on STI and HIV and show confidence in her/his ability to counsel the client.

The counsellor should maintain a professional attitude, be non-judgmental and provide information and help the client resolve her/his problems in an ethical manner. At the same time, it is important to be sensitive to local culture when working with clients of the opposite sex. For example, issues of body language, physical space between a woman and man, and other such, are often determined within a given socio-cultural norm of acceptability.

6. Swati refers Mayank to a Drop-in-Centre (DIC). What are the services an IDU can access in a DIC? Discuss how referrals can be done in an effective manner.

A Drop-in-Centre is a hub for services which an IDU can access as per his needs and convenience. A DIC is conceptualized as a 'safe space' where IDUs can come together and find a 'common voice.' Some of the services provided include Needle Syringe Exchange, IEC materials dissemination, psychosocial support, ulcer/abscess management, condom distribution,

and rest and recreation facilities.

For referrals to be effective the counsellor needs to work with the client to determine what her/his priority needs are, and explain which needs can be met with by the clinic, and how a referral system would help to address other needs. Clients should be referred to services that are appropriate to their culture, language, sex, sexual orientation, age and developmental level. It's also important to verify the completion of a referral for the system to be effective.


NIRODH

CASE-STUDY 3: SAMEER'S CASE

Sameer is a 22 year old student. He lives in a hostel away from his family. He visits the counsellor as he is worried he may have contracted STI or HIV. He appears uncomfortable. He reports that he has had sexual intercourse with his girlfriend a week ago. This was the first contact for both of them. He lacks knowledge and information on STI and HIV.

Ask any participant to summarize the case study presented in the film clip highlighting important issues covered in the film. Generate a discussion by asking the participants the following:

1. What are some of the **factors that make youth vulnerable to STI and HIV**?
2. What are some of the **common myths and misconceptions** that young people like Sameer have regarding STI and HIV?
3. **Counselling skills**:
   In the film clip Sameer appeared nervous and anxious. What strategies did Swati employ to get him to open up? What other strategies may be used?
4. **Risk reduction:**
   As Sameer is a young college going boy:
   a. Would counselling a client of his age on ABC (Abstinence, Being Faithful, Correct and consistent condom use) have been helpful? What other factors assume importance when counselling youth?
   b. Swati demonstrates the available condom to the client. What other information can be given to a client to make condoms seem like an attractive option?
5. What factors contribute to making the **counselling facility** a 'youth-friendly' one?

Points to cover in the discussion:

1. What are some of the factors that make youth vulnerable to STI and HIV?

Sexually active, unmarried youth are at high risk for STI and HIV not only on account of psychological and behavioural factors but also for biological and social reasons. Psychological factors that put many youth at increased risk for STI and HIV include a general sense of invulnerability, the desire to try new experiences, and the willingness to take risks, including changing sexual partners often or having a partner who has

multiple partners. In addition, many adolescents lack basic knowledge of STI and HIV transmission that contributes to risk-taking behaviors, often find it difficult to use condoms correctly and consistently, or lack communication and negotiation skills, making condom use difficult.

2. What are some of the common myths and misconceptions that young people like Sameer have regarding STI and HIV?

There are a number of myths and misconceptions that youth have. These arise on account of lack of credible and reliable sources of information on sex and sexuality, as young people often get their information from peers, who may be themselves misinformed, or unreliable sources such as pornographic literature and internet sites.

Some common misconceptions:

- You can tell if a person has HIV/AIDS by looking at her/him
- Having sex with a 'trusted' partner is 100% safe from any risk
- A boy is not 'macho' enough if he doesn't have many girl friends
- STI can be cured by having sex with a virgin

Many youngsters mistakenly believe that emergency birth control pills can provide protection from STI. They need to know that contraceptive pills, whether emergency pills or regular oral contraceptives, can do nothing to protect against STI. Further, it is also important to mention that frequent use of emergency contraception is not advised, and the pills are not to be used as a substitute for oral contraceptives.

It is important to explore with the client what she/he believes as 'facts' and to guide her/him through a process of acquiring correct information.

3. COUNSELLING SKILLS:

In the film clip Sameer appeared nervous and anxious. What strategies did Swati employ to get him to open up? What other strategies may be used?

Anxiety and nervousness may arise due to a lack of awareness, uncertainty of outcomes, discomfort and embarrassment with a clinic setting, and the personal nature of the issues that are being discussed. It is important to develop rapport with the client and assure her/him of full confidentiality. Swati's reassurance, display of patience, and her non-

judgmental attitude helped in getting Sameer to relax and discuss his concerns with her. Having an open discussion and helping a young person express her/his feelings are important. The counsellor may use a variety of micro-counselling skills to help the client open up, such as asking them open-ended questions like 'you appear anxious...', or 'what are you thinking about?'.

4 .RISK REDUCTION:

Sameer is a young college going boy:

a. Would counselling a client of his age on ABC have been helpful? What other aspects assume importance when counselling youth?

The ABC approach encourages young adults to use abstinence (A) until marriage, as the most effective way to avoid HIV infection. Being faithful (B) encourages individuals to eliminate casual sex partners and to practice fidelity within their marriages and sexual relationships. Correct and consistent condom use (C) is the third plank of the ABC approach. As Sameer had already indulged in sex, Swati focused on counselling him on 'B' and 'C'.

When counselling youth, it is important to identify other factors that influence their behaviour, such as peer pressure. It is also important to discuss other risk behaviours or habits for example, alcohol intake and substance abuse.

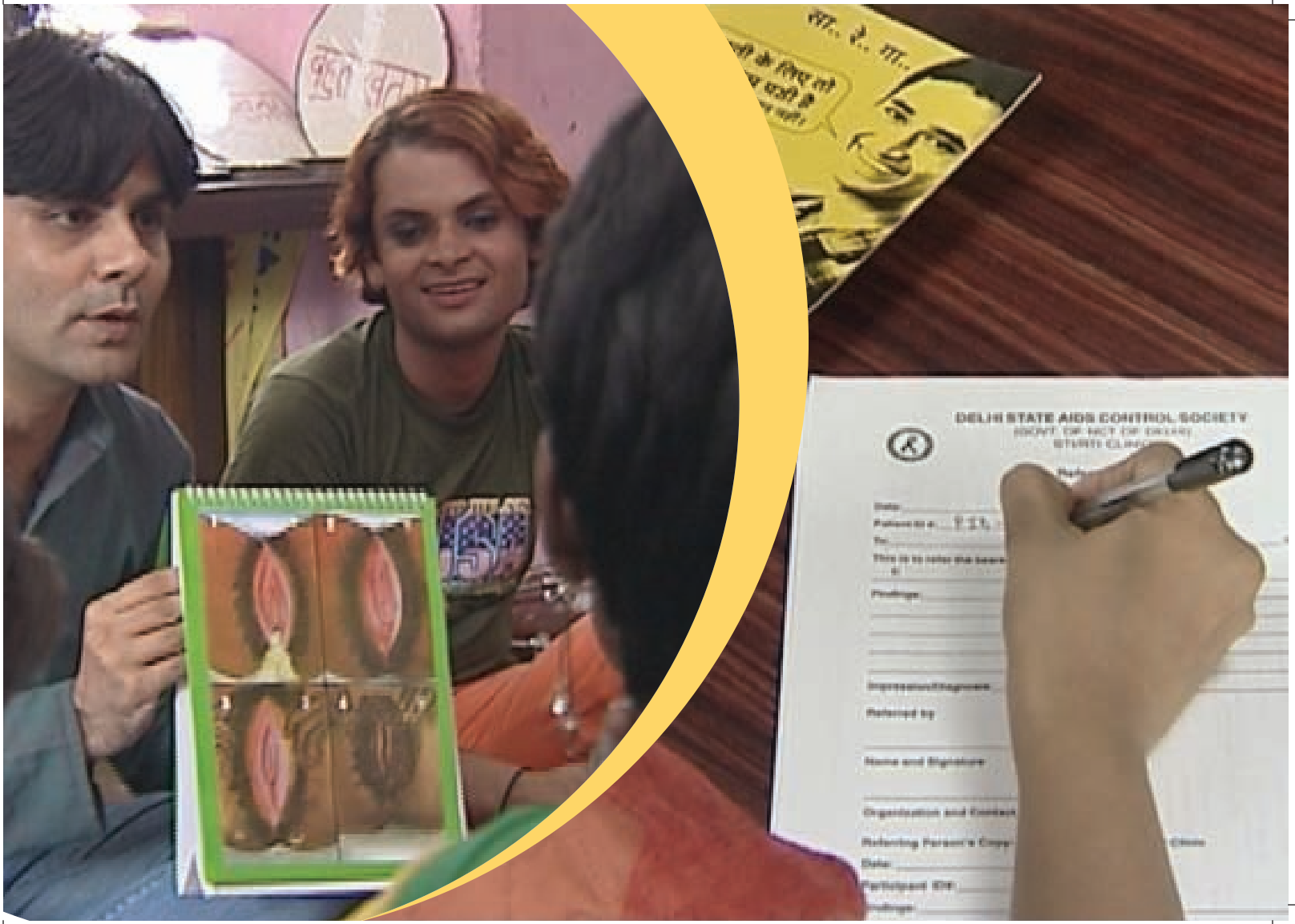
b.Swati demonstrates the available condom to the client. What other information can be given to a client to make condoms seem like an attractive option?

As mentioned in the case of Rani, providing clients information on alternatives available is important. A client may choose to use any alternative available. Providing information on the variety of condom types is useful, for example the counsellor can let the client know that flavoured, ribbed and dotted condoms can enhance the pleasure during sexual intercourse.

5. What factors contribute to making the counselling facility a 'youth-friendly' one?

A 'youth' or 'adolescent' friendly counselling facility should have a comfortable and non-threatening environment that is conducive to maintaining privacy and confidentiality. It should ideally be located close to where youth/adolescents gather, making it easily accessible to them. The provision of both counselling

and curative services, adequate space for stocking visual and take away aids, and timings that are convenient for young people are other important factors. It is also vital to have a counsellor who has been trained in handling issues on adolescent/youth reproductive health and sexuality.


DELHI STATE AIDS CONTROL SOCIETY

CASE-STUDY 4: SUNDAR'S CASE

Sundar is a motor mechanic, who lives alone in city. He reports having multiple male partners. However, he has been reluctant to seek treatment in the past. He is now diagnosed with syphilis.

Ask any participant to summarize the case study presented in the film clip highlighting important issues covered in the film. Generate a discussion by asking the participants:

1. Swati mentions that MSM do not come easily to the STI clinics for treatment. Discuss **factors that prevent them from accessing services.**
2. What are some of the **issues to keep in mind** while counselling MSM?
3. Swati said she was uncomfortable with the idea of alternate sexuality. Are there any other examples where **personal beliefs are in conflict with job requirements**?
4. Swati discusses some risk reduction strategies with Sundar. List the **safer sex options** that can be discussed with an MSM client.
5. Most often clients will listen to the counsellor when diagnosis is recent. What **strategies** should a counsellor use to ensure the client remains motivated towards treatment, follow-up and risk reduction?
6. Why it is important for the counsellor to fill in the form and registers? How do these forms feed into the **reporting system** of the clinic?
7. Sundar is a migrant to the city. What are some of the **factors that put migrants at risk** of STI and HIV?

Points to cover in the discussion:

1. **Swati mentions that MSM do not come easily to the STI clinics for treatment. Discuss factors that prevent them from accessing services.**

   Same sex activity still continues to be stigmatized in India. Negative attitudes force many MSM to hide their sexuality from others and even themselves. This can lead to feelings of guilt, self-hatred, and life-long patterns of denial and shame, that can further lead to substance abuse and depression. MSM are often

reluctant to come to clinics for services as they are worried about revealing their status and about issues surrounding confidentiality, as also anxiety about the provider's attitude towards alternate sexuality.

2. What are some of the issues to keep in mind while counselling MSM?

MSM is a term meant to describe specific behaviour, and is not an identity for a specific population group. Many men who think about themselves as heterosexuals may have sex with other men for a variety of reasons. Many MSM will also have sexual relationships with women. In some cases, they may also marry. It is appropriate, as Swati does, to use the term 'partner' that is a neutral one, covering both men as well as women.

Often what influences male sexual identity is the role taken within a sexual relationship. Penetrating men are often likely to consider themselves heterosexual. The passive penetrated partner is likely to be more 'feminine.' Some men will alternate roles. Counsellors will need to find out whether a client takes an active or passive role during penetrative sex. Receptive partners, especially during anal sex, are at higher risk of infection.

Sex between men always has a degree of emotional impact, whether it is joy or sadness, pride or shame. Addressing emotions is a vital part of counselling. This is because they affect a client's attitude towards protecting himself and his partners from HIV and other STI.

REMEMBER!

ATTITUDES AND SKILLS

- Be aware of your personal feelings and be able to put them aside
- Refer your client to another counsellor if you are uncomfortable working with him
- Ensure that you keep your client's status confidential
- Try and see the situation from his point of view
- Avoid judging or condemning his behaviour in words, tone, or gestures
- Use positive language, for example avoid words like 'normal' or 'natural' to describe sex between men and women, and 'abnormal' and 'unnatural' for sex between men.

Lesbian Gay Bisexual Transgender (LGBT) terminology

HIJRA: Person born with biological male features who identifies as female. Hijras in India have their own form of social organization and form their own parallel society.

TRANSGENDER: Person anatomically born of one sex but more comfortable with a different gender identity and seeks to express this through attire, sex- reassignment surgery etc.

TRANSSEXUAL: Person anatomically born of one sex but adopts a different gender identity though sex change operation/sex reassignment surgery.

TRANSVESTITE: Person anatomically born of one sex but prefers to wear clothes of the other gender.

LESBIAN: Woman emotionally, sexually and romantically attracted to other women.

GAY: Man emotionally, sexually and romantically attracted to other men.

BISEXUAL: Person who is attracted emotionally, sexually and romantically to both men and women.

KOTHI: Male homosexual who is effeminate and usually takes a passive/ receptive role in sex.

PANTHI: Male 'masculine' partner of Kothi.

3. **Swati said she was uncomfortable with the idea of alternate sexuality. Are there any other examples where personal beliefs are in conflict with job requirements?**

   Generate a discussion on how personal beliefs can conflict with job requirements. Ask the participants to list personal beliefs on a range of subjects (pre-marital sex, homosexuality, abortion, sex work, and such like) and discuss what makes them uncomfortable. Discuss the consequences of conflict between personal beliefs and value systems and the requirements of their job as counsellors. Also brainstorm on strategies to deal with the same.

4. **Swati discusses some risk reduction strategies with Sundar. List the safer sex options that can be discussed with an MSM client.**

   All sexual acts are not at equal risk. However, it's important to explain to the client the potential risk that may arise from each act, and to provide risk reduction options. For example:

   - Using a condom for all vaginal, oral and anal intercourse
   - Using water-based lubricants, especially for anal intercourse
   - Having non-penetrative sex; using alternatives such as kissing, masturbation, mutual masturbation, using sex toys, massage, hugging, rubbing, and such like.

5. **Most often clients will listen to the counsellor when diagnosis is recent. What strategies should a counsellor use to ensure the client remains motivated towards treatment, follow-up and risk reduction?**

   It is important to personalize information to the client's context. This will ensure better compliance. Working with the client on strategies best suited to him is important. The counsellor should assist the client in resolving her/his issues, rather than dictating solutions to the client.

6. **Why it is important for the counsellor to fill in the form and registers? How do these forms feed into the reporting system of the clinic?**

   Records should be maintained for future reference and to assist the counsellor in compiling monthly reports. These will be fed into a computer and sent to the SACS (State AIDS Control Society). This data will

provide the clinic with epidemiological data, profile of clients visiting the clinic, nature of infection etc.

7. Sundar is a migrant to the city. What are some of the factors that put migrants at risk of STI/HIV?

An important source of HIV related vulnerability is mobility and migration, mobility being defined as a change of location and migration being defined as a change of residence. India, home to the third highest number of HIV positive people in the world, is characterized by widespread and fluid migration and mobility. Once migrants reach their destination, language and other difficulties lead to feelings of discontinuity and transition that enhance loneliness and/or sexual risk taking. Risk taking may be reinforced by a lack of HIV/AIDS awareness, information and social support networks at both source and destination points, which cumulatively contribute to a migrant's vulnerability. Back home, spouses of migrants are also vulnerable to HIV if their husbands return on a regular basis and have become infected with HIV.

REMEMBER!

ASK YOURSELF SOME REFLECTIVE QUESTIONS ABOUT WORKING WITH MSM:

- Do I approve or disapprove of sexual relations between men?
- Why do I feel that way?
- How might it affect my work?
- If I were an MSM, what type of support might I need from a counsellor?
- How would I want him or her to treat me?

Conclusion

At the end of the film viewing followed by discussions, the facilitator may generate a discussion on 'Dealing with Counsellor Burnout.'

Burnout is often observed among counsellors. In this context, self care is important. Self care is an intrinsic, continuous and highly important activity for the counsellor. If a counsellor is not mentally and physically healthy, her/his ability to provide support to clients is limited.

The facilitator can encourage a discussion around some of the reasons for burnout.

It is important that the counsellor be able to identify what causes her/him to feel burnout as this influences performance of her/his task. Some reasons that could lead to burnout include:

- Performance of repeated activities over time, which seem to be insignificant
- Lack of appreciation for a certain task or overall effort at work
- Strong pressure to perform at work
- Conflict in work relationships
- Lack of opportunities for expression and improvement
- Presence of unresolved personal conflicts outside of the work environment

The first step the counsellor should take is recognizing the causes that lead to burnout. The next step would involve the counsellors' response to the situation. Each individual may deal differently with burnout. As human beings, some counsellors are naturally passive and tend to surrender to their own circumstances, for example, putting themselves in the position of victims. This leads to feelings of hopelessness and powerlessness, which increases the difficulty of dealing with the situation, resulting in either a delay in eliminating burnout, or increased intensity. However, there are others who are proactive towards with the situation.

The facilitator should use this opportunity to highlight some measures that the counsellor can use to deal with burnout.

In a profession where human relationships are so intrinsically related to work, it is sometimes inevitable to experience distress or burnout. On these occasions, it is important that counsellors effectively remediate burnout

in order to invoke balance in both their professional and personal lives.

Sometimes counsellors perform a kind of mental 'self mutilation' in which they take responsibility for anything that goes wrong in a counselling session, or with a client. In this context, feelings of powerlessness and hopelessness will remain obstacles and can perpetuate and affect the counsellor's personal life. In these instances, it is important to stop and take stock, to re-assess one's perception towards certain events and situations.

Strategies that can help a counsellor with self care:

- Developing rapport with co-workers and following a team approach. This will smoothen operations within the system
- Sharing information with peer groups and work related support is helpful in reducing stress
- Relaxation techniques such as imagery, meditation and breathing can help in dealing with burnout
- Music and introspection are also a good combination for improving the state of mind of a person
- Exercise and a balanced diet are other important factors
- Developing hobbies and involvement in recreation can be helpful
- Taking courses, and updating ones self on new developments in one's profession helps to enhance work-related skills, and reduces boredom at the work place

NOTES

NOTES

National AIDS Control Organisation

India's voice against AIDS

Department of AIDS Control

Ministry of Health & Family Welfare, Government of India

www.nacoonline.org